

D05/S/a

**NHS STANDARD CONTRACT
FOR STEREOTACTIC RADIOSURGERY AND STEREOTACTIC RADIOTHERAPY
(INTRACRANIAL) (ALL AGES)**

SCHEDULE 2- THE SERVICES – A. SERVICE SPECIFICATIONS

Service Specification No.	D05/S/a
Service	Stereotactic Radiosurgery and Stereotactic Radiotherapy (Intracranial) (All Ages)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Stereotactic radiosurgery (SRS) and stereotactic radiotherapy (SRT) are methods of delivering precisely targeted radiotherapy treatment. For the purposes of this specification SRS is a highly conformal radiotherapy treatment to a precisely delineated target volume. SRS is delivered using stereotactic localisation techniques. SRS is delivered in 1 fraction. A multidisciplinary team of neurosurgeons, neuro-oncologists and neuroradiologists will be involved in SRS case selection, treatment planning and delivery.

SRT is a highly conformal fractionated radiotherapy treatment to a precisely delineated target volume, delivered using stereotactic localisation techniques. For the purposes of this specification SRT is delivered in 2 to 5 fractions. SRT delivered in greater than 5 fractions is covered by a separate specification. A multidisciplinary team of neurosurgeons, neuro-oncologists and neuroradiologists will be involved in SRT case selection, treatment planning and delivery.

Patients of all ages may benefit from SRS / SRT. The treatment is usually carried out with the patient awake and therefore the patient needs to be compliant. Young children and non-compliant adults can be treated using general anaesthesia.

Stereotactic Radiosurgery and Stereotactic Radiotherapy can be provided using one of several technologies. This service specification covers SRS/SRT whether delivered

by Gamma Knife, Cyberknife or any other linear accelerator-based technology. Departments wishing to provide such service will have access to technologies with up-to-date dose planning.

This specification applies to services delivering SRS/SRT for the treatment of cranial indications and which will identify the activity using Office of Population Censuses and Surveys (OPCS) code A10.7 (stereotactic radiosurgery to tissue of brain) in combination with the appropriate International statistical classification of diseases and related health problems (ICD-10) diagnostic code.

There is evidence to support the use of stereotactic radiosurgery for a wide range of cranial indications including arteriovenous malformations, acoustic neuroma, meningioma, pituitary adenoma, ocular melanoma, trigeminal neuralgia and selected sub-groups of patients with cerebral metastases.

The prevalence of these conditions varies from less than one per 100,000 population to up to 30 per 100,000 though not all cases will be suitable for treatment with stereotactic radiosurgery. For example, it is estimated that the prevalence of patients with cerebral metastases suitable for treatment with SRS is between 3 and 4 per 100,000.

The following references identify the evidence for the clinical and cost effectiveness of SRS/SRT.

References

- The clinical and cost effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for arteriovenous malformations: an evidence based review , Pennant, Bayliss, Routh, Moore, West Midlands Health Technology Collaboration, University of Birmingham, 31/3/10
- The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for acoustic neuromas: an evidence based review, Greenheld, Fry-Smith, Routh, Moore, Unit of Public Health and Epidemiology, University of Birmingham, 1/4/10
- The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for pituitary adenomas: an evidence based review, Greenheld, Fry-Smith, Routh, Moore, Unit of Public Health and Epidemiology, University of Birmingham, 8/6/10
- The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for trigeminal neuralgia: an evidence based review, Dretzke, Fry-Smith, Routh, Moore, Unit of Public Health and Epidemiology, University of Birmingham, 3/6/10
- Solberg TD, Medin PM, Mullins J, Li S. Quality assurance of immobilization and target localization systems for frameless stereotactic cranial and extracranial hypofractionated radiotherapy. *Int J Radiat Oncol Biol Phys.* 2008;71(1 Suppl):S131-5
- Palta JR, Liu C, Li JG. Current external beam radiation therapy quality assurance guidance: does it meet the challenges of emerging image- guided technologies? *Int J Radiat Oncol Biol Phys.* 2008;71(1 Suppl):S13-7
- Galvin JM, Bednarz G. Quality assurance procedures for stereotactic body

- radiation therapy. *Int J Radiat Oncol Biol Phys.* 2008;71(1 Suppl):S122-5
- Das IJ, Cheng CW, Watts RJ, Ahnesjö A, Gibbons J, Li XA, Lowenstein J, Mitra RK, Simon WE, Zhu TC; TG-106 of the Therapy Physics Committee of the AAPM. Accelerator beam data commissioning equipment and procedures: report of the TG-106 of the Therapy Physics Committee of the AAPM. *Med Phys.* 2008 Sep;35(9):4186-215
 - The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for trigeminal neuralgia: an evidence based review; A West Midlands Health Technology Assessment Collaboration Report Dretzke, Fry-Smith, Routh, Moore June 2010 Health Technology He
 - The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for arteriovenous malformations: an evidence based review; A West Midlands Health Technology Assessment Collaboration Report Pennant, Bayliss, Routh, Moore March 2010
 - The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for cavernous haemangioma: an evidence based review; A West Midlands Health Technology Assessment Collaboration Report Bayliss, Routh, Moore June 2010
 - The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for acoustic neuroma: an evidence based review; A West Midlands Health Technology Assessment Collaboration Report Greenheld, Fry-Smith, Routh, Moore April 2010
 - The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for meningiomas: an evidence based review; A West Midlands Health Technology Assessment Collaboration Report Uthman, Fry-Smith, Routh, Moore September 2010
 - The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for ocular melanoma: an evidence based review; A West Midlands Health Technology Assessment Collaboration Report; Uthman, Fry-Smith, Routh, Moore September 2010
 - The clinical and cost-effectiveness of stereotactic radiosurgery and fractionated stereotactic radiotherapy for pituitary adenomas: an evidence based review; A West Midlands Health Technology Assessment Collaboration Report; Greenheld, Fry-Smith, Routh, Moore June 2010
 - Additional competence training in neurosurgical (Stereotactic) radiosurgery; Kemeny A, Reulen HJ, Cunha É Sa M, Trojanowski T; *Acta Neurochir (Wien).* 2012 May;154(5):941-5
 - B01/S/a Radiotherapy NHS England
 - B01/S/b Brachytherapy and Molecular Radiotherapy NHS England

2. Scope

2.1 Aims and objectives of service

Aims and objectives of service

The service aims to:

- Improve both life expectancy and quality of life for patients that meet the requirements of the national commissioning policy for Stereotactic Radiosurgery/Radiotherapy (SRS/SRT).

The service will deliver the following objectives;

The service will deliver the aim to improve life expectancy and quality of life for patients by:

- Making accurate diagnosis;
- Making accurate assessment of the suitability and deliverability of SRS/SRT in the context of each patient's overall management plan;
- Providing safe services which comply with recommendations and regulations as detailed in section 2.2 of this document;
- Providing equitable access through compliance with national commissioning policy;
- Providing timely access through compliance with national waiting times requirements.

2.2 Service description/care pathway

Service description

The service will provide assessment services to determine the suitability of individual cases for SRS/SRT. The service will provide SRS/SRT to patients who, following assessment, are considered suitable by the Neuroscience Brain and Central Nervous System (CNS) Multidisciplinary teams and in accordance with the national commissioning policy.

The treatment team for Stereotactic Radiosurgery / Stereotactic Radiotherapy will involve neurosurgeons and radiation oncologists supported by neuroradiologists, medical physics staff, health technology staff, radiographers, clinical nurse specialists and administrative support.

The specialist team must meet on a regular basis for multi-disciplinary discussion of each patient during planning and treatment phases of the care pathway.

Radiographer staffing levels will follow the guidelines laid out in the College of Radiographers document 'Radiographic Staffing: Short Term Guidance 2005. Benchmark for Standard Core Functions within Radiotherapy'

Expertise in intracranial stereotactic radiosurgery requires added competence for

Neurosurgeons and Oncologists. Individual providers must demonstrate appropriate specialist training in SRS/SRT beyond equipment-specific practical training and ensure sufficient throughput to maintain competence.

General Paediatric care

When treating children, the service will additionally follow the standards and criteria outlined in the Specification for Children's Services (attached as Annex 1 to this specification)

Care pathways

Assessment and Treatment Planning

The service will accept referrals from consultant medical staff and appropriate specialist multi-disciplinary teams (MDTs) in line with eligibility and referral guidelines. Referrals will be discussed in an MDT prior to accepting the patient for treatment.

The MDT will include, as a minimum, a Neurosurgeon, a Clinical Oncologist specialising in Neuro-oncology and a Neuro-radiologist.

There must be clear documented pathways for each condition treated that shows:

- The process for ensuring that each patient is reviewed by an appropriate MDT which make the decision about the most appropriate treatment
- The process for determining where the patient is treated
- Where in each care pathway the role of SRS/SRT provider starts and finishes
- The process for ensuring that the pathway is seamless and has no avoidable delays

Patients potentially suitable for SRS/SRT will be reviewed by a specialist diagnostic (MDT) and by the SRS MDT. The specialist MDT will determine whether SRS is an appropriate treatment for each patient. The SRS MDT will determine whether SRS can be performed. These multi-disciplinary discussions may be held synchronously if appropriate specialists are in attendance.

For patients with brain metastases, the decision to refer to a Neurosciences Brain and Central Nervous System (CNS) MDT will be made by their disease-specialist MDT which must consider the role of aggressive management of brain metastases with SRS or surgery within the patient's overall oncological management.

For patients being referred for indications other than brain metastases, the decision to offer SRS/SRT will be made by the appropriate sub-specialist MDT e.g. the base of skull MDT or the neuro-vascular MDT.

Following discussion at an SRS MDT patients accepted for SRS/SRT treatment will be seen by a clinician who is a core member of that MDT. This clinician will discuss with the patient their condition, their treatment options, the rationale for SRS/SRT treatment and will plan and supervise the treatment.

If patients are turned down for SRS/SRT treatment by the SRS MDT on clinical

grounds, that decision will be conveyed to the patient by the referring MDT, with the support of the SRS MDT.

Where no further investigations are required, patient assessment will be completed within 14 days of the first discussion at the SRS MDT unless decided otherwise between the patient, the SRS MDT and the referring specialist MDT.

The patient will be provided with a full management plan within 14 days of their assessment. The plan will clearly indicate the overall management and the role of SRS. All patients will be provided with detailed condition specific information booklets and furnished with relevant website address during informal counselling. Patients will have access to a specialist nurse or keyworker throughout the referral and treatment process.

Within 5 days of the definitive management plan being established, the diagnosis and management plan will be communicated to the referring consultant/MDT and the General Practitioner (GP).

On agreement of a management plan which includes SRS/SRT treatment, the patient's consent must be formally documented

The patient's treatment will be carried out in line with clear, documented treatment protocols for the use of SRS/SRT in the agreed indications. Each department will have a fully funded, externally accredited quality management system in place (Towards Safer Radiotherapy section 4.3).

Treatment protocols will ensure that target definition is performed by either a subspecialised neuro-surgeon or neuro-oncologist with input from a neuroradiologist before a treatment plan is created. The radiation dose and treatment plan will be approved or countersigned by an appropriately trained and accredited practitioner according to Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

A method which is independent of the planning computer and independent of the person producing the computer generated plan will be in place for checking the monitor unit calculation/treatment times (Towards Safer Radiotherapy 5.7.1).

Discharge

Patients will be discharged back to the referring consultant/MDT following treatment, with the exception of those conditions detailed below.

Follow up protocols and recommendations will be sent to referring physicians with whom shared care is arranged. This applies particularly to patients for whom transport may present difficulties.

- **Arteriovenous Malformations** - Patients who have demonstrated obliteration on Magnetic resonance imaging (MRI) and formal angiography may be discharged from further follow up.
- **Vestibular Schwannoma (Acoustic Neuroma)** - Patients with Vestibular

Schwannoma will have follow up at 1,2,3,5 years. Follow up includes MRI, audiology and facial nerve assessment.

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

*Note: for the purposes of commissioning health services this EXCLUDES patients who, whilst resident in England are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

Specifically this service is for all patients requiring SRS/SRT as determined by the appropriate clinical specialists and in accordance with the national commissioning policy.

2.4 Any acceptance and exclusion criteria

- The service will accept referrals from consultant medical staff and appropriate specialist MDTs in line with eligibility and referral guidelines. Patients will generally be under the care of an oncologist and/or neurosurgeon.
- Children will only be treated at a centre that has the necessary facilities for treating paediatric cases and that is compliant with the document 'Improving outcomes in children and young people with cancer – August 2005'. Typically this will require appropriate overnight accommodation and paediatric anaesthetic capabilities.

2.5 Interdependencies with other services

- The service will ensure close working relationships with the local Neurosciences Brain and CNS, CNS Cancer Network and other tumour site specific Multi-disciplinary teams as appropriate to the needs of individual patients.
- For the treatment of Arteriovenous Malformations the service must have access to angiography services and be able to safely transport patients from these services to the SRS/SRT treatment area.
- There is significant commonality between the standards and requirements for providing External Beam Radiotherapy and SRS/SRT. Providers must ensure compliance with the relevant parts of the External Beam Radiotherapy service specification contained in Appendix 1 of this document.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

National Standards include:

- Service guidance for improving outcomes for people with brain and other central nervous system tumours – June 2006 (<http://guidance.nice.org.uk/csgbraincns>)
- NICE Interventional Procedure Guidance – Trigeminal Neuralgia (<http://guidance.nice.org.uk/IPG85>)

Other guidance documents include:

- Radiotherapy dose-fractionation” available at <http://www.rcr.ac.uk/publications.aspx?PageID=149&PublicationID=229>
- International RadioSurgery Association AVM Guidelines: <http://www.irsa.org/AVM%20Guideline.pdf>
- International RadioSurgery Association Vestibular Schwannoma Guidelines: <http://www.irsa.org/AN%20Guideline.pdf>
- International RadioSurgery Association Pituitary Guidelines: <http://www.irsa.org/Pituitary%20Guideline.pdf>
- International RadioSurgery Association Brain Metastases Guidelines: <http://www.irsa.org/Metastatic%20Guideline.pdf>
- Physics Aspects of Quality Control in Radiotherapy, IPEM Report 81, Institute of Physics and Engineering in Medicine, York 1999
- Acceptance Testing and Commissioning of Linear Accelerators, Chapter 13: Commissioning for Stereotaxis, IPEM Report 94, Institute of Physics and Engineering in Medicine, York 2006
- Towards Safer Radiotherapy, Royal College of Radiologists, 2008
- Department of Health – You're Welcome quality criteria: making health services young people friendly <http://www.dh.gov.uk/en/Publicationsandstatistics/>
- Department of Health – National Service Framework Children and Maternity. <http://www.webarchive.nationalarchives.gov.uk>

Core Standards

The service must demonstrate compliance with the recommendations of The Royal College of Radiologists, Society and College of Radiographers, Institute of Physics and Engineering in Medicine, National Patient Safety Agency, British Institute of Radiology document 'Towards Safer Radiotherapy.' London: The Royal College of Radiologists, 2008.

The service must demonstrate compliance with the Ionisation Radiation Medical Exposure) Regulations 2000The service must demonstrate compliance with Ionising Radiation Regulations (IRR99).

The service must demonstrate compliance with the Radioactive Substances Act (RSA93) if applicable.

The service will follow the Institute of Physics in Engineering Medicine 'Guidelines

for the provision of a Physics Service for Radiotherapy' 2002.

The specialist team will demonstrate an appropriate level of knowledge, training and experience commensurate with the provision of a safe and effective service which, as a minimum, meets the theoretical and practical training requirements needed to meet the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2000).

4. Key Service Outcomes

Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of Breach
Clinical Indicators				
Tumours	To be agreed			
Obliteration of AVM nidus	Obliteration of the AVM nidus measured by conventional angiography at 3 years post treatment	70% of AVMs with nidus obliterated at 3 years	Annual audit report	Exception report and plan for remediation
Endocrinological normalisation in endocrinologically active pituitary adenoma	Routine endocrinology monitoring shows levels within normal limits by 2 years after treatment	50% within normal limits within 2 years of treatment	Annual audit report	Exception report and plan for remediation
Improvement in facial pain in patients with trigeminal neuralgia	Patient reported reduction in level of pain compared to pre-treatment measurement within 1 year of treatment	65% of patients report reduction in pain within 1 year of treatment	Annual audit report	Exception report and plan for remediation
Service Indicators				

Reporting of errors and near misses	Errors and near misses reported in compliance with Towards Safer Radiotherapy recommendations	100% compliance	Annual audit report	Exception report and plan for remediation
Waiting times	Compliance with national waiting times and cancer waiting times requirements	100% with national targets	Annual audit report	Exception report and plan for remediation
Peer review	Participation in the national peer review programme for radiotherapy	100%	Annual audit report	Exception report and plan for remediation
Information	Collection and submission of the mandated national radiotherapy dataset (RTDS)	100%	Annual audit report	Exception report and plan for remediation

Interim for Adoption from 07/10/13

ANNEX 1 TO SERVICE SPECIFICATION

PROVISION OF SERVICES TO CHILDREN

Aims and objectives of service

This specification annex applies to all children's services and outlines generic standards and outcomes that would be fundamental to all services.

The generic aspects of care:

The Care of Children in Hospital (HSC 1998/238) requires that:

- Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital.
- Children requiring admission to hospital are provided with a high standard of medical, nursing and therapeutic care to facilitate speedy recovery and minimize complications and mortality.
- Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities.
- Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care.
- Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child; Accommodation is provided for them to remain with their children overnight if they so wish.

Service description/care pathway

- All paediatric specialised services have a component of primary, secondary, tertiary and even quaternary elements.
- The efficient and effective delivery of services requires children to receive their care as close to home as possible dependent on the phase of their disease.
- Services should therefore be organised and delivered through "integrated pathways of care" (National Service Framework for children, young people and maternity services (Department of Health & Department for Education and Skills, London 2004))

Interdependencies with other services

All services will comply with Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies – Department of Health

Imaging

All services will be supported by a 3 tier imaging network ('Delivering quality imaging services for children' Department of Health 13732 March 2010). Within the network:

- It will be clearly defined which imaging test or interventional procedure can be performed and reported at each site
- Robust procedures will be in place for image transfer for review by a specialist radiologist, these will be supported by appropriate contractual and information governance arrangements
- Robust arrangements will be in place for patient transfer if more complex imaging or intervention is required
- Common standards, protocols and governance procedures will exist throughout the network.
- All radiologists, and radiographers will have appropriate training, supervision and access to CPD
- All equipment will be optimised for paediatric use and use specific paediatric software

Specialist Paediatric Anaesthesia

Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training.¹ All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training² and should maintain the competencies so acquired³ *. These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).

As well as providing an essential co-dependent service for surgery, specialist anaesthesia and sedation services may be required to facilitate radiological procedures and interventions (for example MRI scans and percutaneous nephrostomy) and medical interventions (for example joint injection and intrathecal chemotherapy), and for assistance with vascular access in babies and children with complex needs such as intravenous feeding.

Specialist acute pain services for babies and children are organised within existing departments of paediatric anaesthesia and include the provision of agreed (hospital wide) guidance for acute pain, the safe administration of complex analgesia regimes including epidural analgesia, and the daily input of specialist anaesthetists and acute pain nurses with expertise in paediatrics.

*The Safe and Sustainable reviews of paediatric cardiac and neuro- sciences in England have noted the need for additional training and maintenance of competencies by specialist anaesthetists in both fields of practice.

References

1. Guidelines for the Provision of Anaesthetic Services (GPAS) Paediatric anaesthetic services. Royal College of Anaesthetists (RCoA) 2010
www.rcoa.ac.uk
2. Certificate of Completion of Training (CCT) in Anaesthesia 2010

3. CPD matrix level 3

Specialised Child and Adolescent Mental Health Services (CAMHS)

The age profile of children and young people admitted to specialised CAMHS day/in-patient settings is different to the age profile for paediatric units in that it is predominantly adolescents who are admitted to specialised CAMHS in-patient settings, including over-16s. The average length of stay is longer for admissions to mental health units. Children and young people in specialised CAMHS day/in-patient settings generally participate in a structured programme of education and therapeutic activities during their admission.

Taking account of the differences in patient profiles the principles and standards set out in this specification apply with modifications to the recommendations regarding the following:

- Facilities and environment – essential Quality Network for In-patient CAMHS (QNIC) standards should apply (<http://www.rcpsych.ac.uk/quality/quality accreditation/audit/qnic1.aspx>)
- Staffing profiles and training - essential QNIC standards should apply.
- The child/ young person's family are allowed to visit at any time of day taking account of the child / young persons need to participate in therapeutic activities and education as well as any safeguarding concerns.
- Children and young people are offered appropriate education from the point of admission.
- Parents/carers are involved in the child/young persons care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Parents/carers who wish to stay overnight are provided with accessible accommodation unless there are safeguarding concerns or this is not in the best interests of the child/ young person.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

Children and young people must receive care, treatment and support by staff registered by the Nursing and Midwifery Council on the parts of their register that permit a nurse to work with children (Outcome 14h Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

- There must be at least two Registered Children's Nurses (RCNs) on duty 24 hours a day in all hospital children's departments and wards.
- There must be an Registered Children's Nurse available 24 hours a day to advise on the nursing of children in other departments (this post is included in the staff establishment of 2RCNs in total).

Accommodation, facilities and staffing must be appropriate to the needs of children

and separate from those provided for adults. All facilities for children and young people must comply with the Hospital Build Notes HBN 23 Hospital Accommodation for Children and Young People NHS Estates, The Stationary Office 2004.

All staff who work with children and young people must be appropriately trained to provide care, treatment and support for children, including Children's Workforce Development Council Induction standards (Outcome 14b Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

Each hospital who admits inpatients must have appropriate medical cover at all times taking account of guidance from relevant expert or professional bodies (National Minimum Standards for Providers of Independent Healthcare, Department of Health, London 2002). "Facing the Future" Standards, Royal College of Paediatrics and Child Health.

Staff must carry out sufficient levels of activity to maintain their competence in caring for children and young people, including in relation to specific anaesthetic and surgical procedures for children, taking account of guidance from relevant expert or professional bodies (Outcome 14g Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

Providers must have systems in place to gain and review consent from people who use services, and act on them (Outcome 2a Essential Standards of Quality and Safety, Care Quality Commission, London 2010). These must include specific arrangements for seeking valid consent from children while respecting their human rights and confidentiality and ensure that where the person using the service lacks capacity, best interest meetings are held with people who know and understand the person using the service. Staff should be able to show that they know how to take appropriate consent from children, young people and those with learning disabilities (Outcome 2b) (Seeking Consent: working with children Department of Health, London 2001).

Children and young people must only receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur (Outcome 7 Essential Standards of Quality and Safety, Care Quality Commission, London 2010 defines the standards and evidence required from providers in this regard). Providers minimise the risk and likelihood of abuse occurring by:

- Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them.
- Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
- Ensuring that people who use services are aware of how to raise concerns of abuse.
- Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.
- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:

- having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse
- separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider
- reporting the alleged abuse to the appropriate authority
- reviewing the person's plan of care to ensure that they are properly supported following the alleged abuse incident.
- Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.
- Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010

All children and young people who use services must be:

- Fully informed of their care, treatment and support.
- Able to take part in decision making to the fullest extent that is possible.
- Asked if they agree for their parents or guardians to be involved in decisions they need to make.

(Outcome 4I Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

4. Key Service Outcomes

Evidence is increasing that implementation of the national Quality Criteria for Young

People Friendly Services (Department of Health, London 2011) have the potential to greatly improve patient experience, leading to better health outcomes for young people and increasing socially responsible life-long use of the NHS. Implementation is also expected to contribute to improvements in health inequalities and public health outcomes e.g. reduced teenage pregnancy and Sexually Transmitted Infections

(STIs), and increased smoking cessation. All providers delivering services to young people should be implementing the good practice guidance which delivers compliance with the quality criteria.

Poorly planned transition from young people's to adult-oriented health services can be associated with increased risk of non adherence to treatment and loss to follow-up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes. When children and young people who use paediatric services are moving to access adult services (for example, during transition for those with long term conditions), these should be organised so that:

- All those involved in the care, treatment and support cooperate with the planning and provision to ensure that the services provided continue to be appropriate to the age and needs of the person who uses services.

The National Minimum Standards for Providers of Independent Healthcare, (Department of Health, London 2002) require the following standards:

- **A16.1** Children are seen in a separate out-patient area, or where the hospital does not have a separate outpatient area for children, they are seen promptly.
- **A16.3** Toys and/or books suitable to the child's age are provided.
- **A16.8** There are segregated areas for the reception of children and adolescents into theatre and for recovery, to screen the children and adolescents from adult patients; the segregated areas contain all necessary equipment for the care of children.
- **A16.9** A parent is to be actively encouraged to stay at all times, with accommodation made available for the adult in the child's room or close by.
- **A16.10** The child's family is allowed to visit him/her at any time of the day, except where safeguarding procedures do not allow this
- **A16.13** When a child is in hospital for more than five days, play is managed and supervised by a qualified Hospital Play Specialist.
- **A16.14** Children are required to receive education when in hospital for more than five days; the Local Education Authority has an obligation to meet this need and are contacted if necessary.
- **A18.10** There are written procedures for the assessment of pain in children and the provision of appropriate control.

All hospital settings should meet the Standards for the Care of Critically Ill Children (Paediatric Intensive Care Society, London 2010).

There should be age specific arrangements for meeting Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These require:

- A choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs;
- Food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background
- Support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.
- For the purposes of this regulation, "food and hydration" includes, where applicable, parenteral nutrition and the administration of dietary supplements

where prescribed.

- Providers must have access to facilities for infant feeding, including facilities to support breastfeeding (Outcome 5E, of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010)

All paediatric patients should have access to appropriately trained paediatric trained dieticians, physiotherapists, occupational therapists, speech and language therapy, psychology, social work and CAMHS services within nationally defined access standards.

All children and young people should have access to a professional who can undertake an assessment using the Common Assessment Framework and access support from social care, housing, education and other agencies as appropriate

All registered providers must ensure safe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines (Outcome 9 Essential Standards of Quality and Safety, Care Quality Commission, London 2010). For children, these should include specific arrangements that:

- ensure the medicines given are appropriate and person-centred by taking account of their age, weight and any learning disability
- ensure that staff handling medicines have the competency and skills needed for children and young people's medicines management
- ensure that wherever possible, age specific information is available for people about the medicines they are taking, including the risks, including information about the use of unlicensed medicine in paediatrics.

Many children with long term illnesses have a learning or physical disability. Providers should ensure that:

- They are supported to have a health action plan
- Facilities meet the appropriate requirements of the Disability Discrimination Act 1995
- They meet the standards set out in Transition: getting it right for young people. Improving the transition of young people with long-term conditions from children's to adult health services. Department of Health, 2006, London